

Reporting Procedure for 3rd Party Incident/Accident

The following procedures are the DIRECT RESPONSIBILITY of the Agency Risk Coordinator.

Anytime there is contact with the public concerning an accident or incident:

1. Immediately report the incident to your supervisor;
2. Fill out a **STANDARD LIABILITY INCIDENT REPORT**;
3. Fill out a **SCOPE OF EMPLOYMENT** form and
4. Send completed copies to the Fiscal Services Risk Management Division

Do not wait for notification of a claim from this office before sending the incident and scope of employment.

When you send in a “Standard Liability Incident Report”, regardless of the type of incident, the form must be filled out by your employees, (**NOT THE CLAIMANT**), with the following questions answered:

WHO

Claimant’s name, address, phone number

Who at your agency was involved: agency name, employee name, position, phone number, etc?

If a State employee is directly involved in an incident or accident, then we need the enclosed “Scope of Employment” Form filled out and signed by the employee’s supervisor. In case of a vehicle accident call the police regardless of who’s at fault and try to obtain a police report.

WHAT happened to the claimant?

Personal Injury

For slip and fall's find out how the claimant was dressed, type of shoes, approximate weight, etc. What were they carrying and how much (arms full, couldn't see where stepping). Total over-all appearance.

Where the claimant was injured (i.e. left leg, right knee, neck, lower back, etc.)

Vehicle Damage

Describe area of damage (i.e. left front fender, passenger side tail light, right door etc.

Describe condition of the vehicle, not any possible pre-existing damage.

Get pictures if possible.

Personal Property Damage

Get a description of the property; note the prior condition of the property if possible.

WHEN

Date and time of incident

WHERE

Exact location of the incident. Pictures of the site are very beneficial, especially for slip and fall incidents.



**State of Oklahoma
Department of Central Services
Risk Management Division**

Scope of Employment

DCS-RISK MGMT P.O. BOX 53364

OKLAHOMA CITY, OKLAHOMA 73152

TEL: 405/521-4999, FAX: 405/522-4442

Incident Date: _____ Time: _____ Claim No (DCS use only): _____

Employee Name: _____ Job Title: _____

State Agency Name _____ Code _____

Division or Dept: _____ Phone _____

Address: _____ City: _____ State: _____ Zip: _____

Type of Employment: ☐ Full Time ☐ Temporary ☐ Volunteer ☐ Contract

Who Authorized This Specific Duty: _____

Please describe in detail what specific duty was being performed at the time of the incident.

Employee Signature

Supervisor Signature

Please Type or Print Name (Supervisor)

Date

Date



State of Oklahoma
Department of Central Services
Risk Management Division

Standard Liability Incident Report

DCS-RISK MGMT P.O. BOX 53364

OKLAHOMA CITY, OKLAHOMA 73152

TEL: 405/521-4999 (24h), FAX: 405/522-4442

Claim No: _____

Agency Information:

Agency Name _____ Agency # _____ Phone _____

Type of Employment: ☐ Full Time ☐ Temporary ☐ Volunteer ☐ Contract

Driver or Employee: _____ Job Title: _____

Div. or Dept: _____ Address: _____ Phone: _____

Specific Duty Being Performed:

Vehicle Information:

Owned By: State _____ Other _____ Make _____ Year _____

Body Type: _____ Vehicle Tag #: _____ Vehicle #: _____

Amount Damage: _____ Where Damaged: _____

Claimant's Name: _____ Phone: _____

Address: _____ City: _____ State: _____ Zip: _____

Was Claimant or Passenger Injured? ☐ Yes ☐ No

Describe _____

Name of Doctor or Hospital: _____

Claimant Vehicle: _____
Make Yr Body Type Damage Amt.

Where Damaged: _____

Claim Form Requested? ☐ Yes ☐ No

Incident Date: _____ Time: _____

Location:

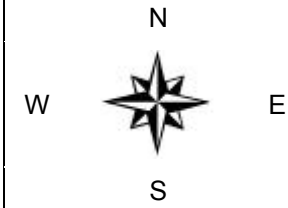
City Street Highway County

Describe Incident:

Was Employee Aware Of Incident? ☐ Yes ☐ No

Remarks:

Diagram of Accident



Car #1 Employee
Car #2 Claimant

Witnesses

Name	Address	Phone
_____	_____	_____
_____	_____	_____
_____	_____	_____

Incident Citations

Authorities reported to: _____ Name: _____

Were there any citations: ☐ Yes ☐ No

Who: _____

What: _____

Reported by: _____

Date: _____ Phone: _____

Driver's signature: _____

Driver's license #: _____